

**CRITERIA FOR PRIOR AUTHORIZATION**

methotrexate subcutaneous injection

**PROVIDER GROUP** Pharmacy  
Professional

**MANUAL GUIDELINES** The following drug requires prior authorization:  
Otrexup® (methotrexate subcutaneous injection)  
Rasuvo® (methotrexate subcutaneous injection)

**CRITERIA FOR RHEUMATOID ARTHRITIS (RA):** (must meet all of the following)

- Patient must have a diagnosis of rheumatoid arthritis
- Must have documentation of inadequate response, contraindication, allergy, or intolerable side effects to at least one first line therapy (example: full dose non-steroidal anti-inflammatory agents)
- Must be prescribed by or in consultation with a rheumatologist
- Dose must be between 10mg and 25mg per week for Otrexup or 7.5mg and 30mg per week for Rasuvo

**CRITERIA FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA):** (must meet all of the following)

- Patient must have a diagnosis of polyarticular juvenile idiopathic arthritis
- Must have documentation of inadequate response, contraindication, allergy, or intolerable side effects to at least one first line therapy (example: full dose non-steroidal anti-inflammatory agents)
- Must be prescribed by or in consultation with a rheumatologist
- Dose must be between 10mg and 25mg per week for Otrexup or 7.5mg and 30mg per week for Rasuvo

**CRITERIA FOR PSORIASIS:** (must meet all of the following)

- Patient must have a diagnosis of psoriasis
- Must have documentation of inadequate response, contraindication, allergy, or intolerable side effects to at least one other therapy (example: full dose non-steroidal anti-inflammatory agents)
- Must be prescribed by or in consultation with a dermatologist
- Dose must be between 10mg and 25mg per week for Otrexup or 7.5mg and 30mg per week for Rasuvo

**LENGTH OF APPROVAL** 6 months